		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039826

Facility Name: Mount Vernon Care Center

Address: 1717 Jefferson St. (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 244-2861 **Fax #** (618) 244-7677

IDPA ID Number: 391516877002

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (c) (3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 06/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	64	Intermediate (ICF)	64	23,424	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,424	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,698	3,103	112	17,913	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,698	3,103	112	17,913	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.47%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	81,134	7,377	4,661	93,172		93,172		93,172			1
2	Food Purchase		78,319		78,319		78,319	(12,666)	65,653			2
3	Housekeeping	51,660	8,826		60,486		60,486		60,486			3
4	Laundry	45,543	9,570		55,113		55,113		55,113			4
5	Heat and Other Utilities			37,830	37,830		37,830		37,830			5
6	Maintenance	15,374		26,552	41,926		41,926		41,926			6
7	Other (specify):*											7
8	**TOTAL General Services**	193,711	104,092	69,043	366,846		366,846	(12,666)	354,180			8
	B. Health Care and Programs											
9	Medical Director			6,100	6,100		6,100		6,100			9
10	Nursing and Medical Records	584,066	28,248	4,733	617,047		617,047		617,047			10
10a	Therapy			2,805	2,805		2,805		2,805			10a
11	Activities	20,564	3,376	1,208	25,148		25,148		25,148			11
12	Social Services	21,389	7	545	21,941		21,941		21,941			12
13	Nurse Aide Training			100	100		100		100			13
14	Program Transportation			512	512		512		512			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	626,019	31,631	16,003	673,653		673,653		673,653			16
	C. General Administration											
17	Administrative	41,857		99,000	140,857		140,857		140,857			17
18	Directors Fees											18
19	Professional Services			1,232	1,232		1,232	12,371	13,603			19
20	Dues, Fees, Subscriptions & Promotions			5,226	5,226		5,226	117	5,343			20
21	Clerical & General Office Expenses	20,298	4,728	15,107	40,133		40,133	2,100	42,233			21
22	Employee Benefits & Payroll Taxes			96,909	96,909		96,909	59,373	156,282			22
23	Inservice Training & Education			384	384		384		384			23
24	Travel and Seminar			1,107	1,107		1,107	117	1,224			24
25	Other Admin. Staff Transportation			653	653		653		653			25
26	Insurance-Prop.Liab.Malpractice			1	1		1	42,732	42,733			26
27	Other (specify):*											27
28	**TOTAL General Administration**	62,155	4,728	219,619	286,502		286,502	116,810	403,312			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	881,885	140,451	304,665	1,327,001		1,327,001	104,144	1,431,145			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** **SEE ACCOUNTANTS' COMPILATION REPORT**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Mount Vernon Care Center #0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			5,404	5,404		5,404	63,112	68,516			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,817	1,817		1,817	168,064	169,881			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			256,545	256,545		256,545	(256,545)				34
35	Rent-Equipment & Vehicles			1,353	1,353		1,353		1,353			35
36	Other (specify):*											36
37	**TOTAL Ownership**			265,119	265,119		265,119	(25,369)	239,750			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,136	35,136		35,136		35,136			42
43	Other (specify):* Nonallowable Costs			9,212	9,212		9,212	(9,212)				43
44	**TOTAL Special Cost Centers**			44,348	44,348		44,348	(9,212)	35,136			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	881,885	140,451	614,132	1,636,468		1,636,468	69,563	1,706,031			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(245)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,815	30		9
10	Interest and Other Investment Income	(170)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(3,358)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(7,570)	43		18
19	Entertainment				19
20	Contributions	(27)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(636)	43		24
25	Fund Raising, Advertising and Promotional	(630)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(104)	43		28
29	Other-Attach Schedule see attached schedule 5A	(390)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,315)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	78,878		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 78,878		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 69,563		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Care Center
Provider #: 0039826
07/01/03 to 06/30/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
Miscellaneous Income	(28)	21
Nonallowable Collection Fees	(362)	19
	(390)	

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Care Center

ID# 0039826

Report Period Beginning: 07/01/03

Ending: 06/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Mount Vernon Care Center **#** 0039826 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,733	0	0	0	0	0	0	0	0	0	12,733	19
20	Fees, Subscriptions & Promotions	0	111	6	0	0	0	0	0	0	0	0	117	20
21	Clerical & General Office Expenses	0	2,128	0	0	0	0	0	0	0	0	0	2,128	21
22	Employee Benefits & Payroll Taxes	0	46,707	0	0	0	0	0	0	0	0	0	46,707	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	117	0	0	0	0	0	0	0	0	0	117	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	42,732	0	0	0	0	0	0	0	0	0	42,732	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	104,528	6	0	0	0	0	0	0	0	0	104,534	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	104,528	6	0	0	0	0	0	0	0	0	104,534	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mount Vernon Care Center # 0039826 **Report Period Beginning:** 07/01/03 **Ending:** 06/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,815	0	59,297	0	0	0	0	0	0	0	0	63,112	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,528)	1,708	169,884	0	0	0	0	0	0	0	0	168,064	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(256,545)	0	0	0	0	0	0	0	0	(256,545)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	287	1,708	(27,364)	0	0	0	0	0	0	0	0	(25,369)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(9,212)	0	0	0	0	0	0	0	0	0	0	(9,212)	43
44	TOTAL Special Cost Centers	(9,212)	0	0	0	0	0	0	0	0	0	0	(9,212)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(8,925)	106,236	(27,358)	0	0	0	0	0	0	0	0	69,953	45

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Residential Centers, Inc.	100%	Jeffersonian Care Center	Mt. Vernon	Caravilla Charitable Corporation		
		Casey Care Center	Mt. Vernon		Mt. Vernon	Lessor
Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions						
with the nursing home during the reporting period.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	24	Board member travel	$	Caravilla Residential Centers, Inc.	100.00%	$ 117	$ 117	1
2	V	19	Professional fees		Caravilla Residential Centers, Inc.	100.00%	12,733	12,733	2
3	V	20	Licenses, dues & subscriptions		Caravilla Residential Centers, Inc.	100.00%	111	111	3
4	V	21	Office supplies & telephone		Caravilla Residential Centers, Inc.	100.00%	2,128	2,128	4
5	V	22	Emp. Benefits & payroll taxes		Caravilla Residential Centers, Inc.	100.00%	46,707	46,707	5
6	V	26	Vehicle, fire & liab. insurance		Caravilla Residential Centers, Inc.	100.00%	42,732	42,732	6
7	V	32	Interest expense		Caravilla Residential Centers, Inc.	100.00%	1,708	1,708	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 106,236	$ * 106,236	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Licenses, dues & subscriptions	$	Caravilla Charitable Corporation	**	$ 6	$ 6	15
16	V	30	Depreciation		Caravilla Charitable Corporation	**	59,297	59,297	16
17	V	32	Interest expense		Caravilla Charitable Corporation	**	169,884	169,884	17
18	V	34	Rent expense	256,545	Caravilla Charitable Corporation	**		(256,545)	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V				**Caravilla Charitable Corporation and Caravilla				27
28	V				Residential Centers, Inc. have the same board of directors.				28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 256,545			$ 229,187	$ * (27,358)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Bauer	President	Board Member	None	None	2 hrs/mtg.		None	$ 0		1
2	Roger Ryan	Vice President	Board Member	None	None	2 hrs/mtg.		None	0		2
3	William Armstrong	Treasurer	Board Member	None	None	2 hrs/mtg.		None	0		3
4	Kay Baker	Secretary	Board Member	None	None	2 hrs/mtg.		None	0		4
5	Ronald O'Daniell	Director	Board Member	None	None	2 hrs/mtg.		None	0		5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Residential Centers, Inc.
Street Address: 2020 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-9596

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	24	Board member travel	Number of beds	235	3	$ 430	$	64	$ 117	1
2	19	Professional fees	Number of beds	235	3	46,754		64	12,733	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	408		64	111	3
4	21	Office supplies & telephone	Number of beds	235	3	7,744		64	2,128	4
5	32	Interest expense	Number of beds	235	3	6,270		64	1,708	5
6										6
7										7
8										8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						46,707	10
11	26	Vehicle, fire & liab. insurance	Direct method						42,732	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 61,606	$		$ 106,236	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Continental Wingate		X	Purchase Facility	$55,560.00	09/01/96	$ 7,402,500	$ 1,954,072	10/01/31	0.0855	$ 167,073	1
2	NCS Healthcare, Inc.		X	Hardware/Software	$689.00	10/31/98	27,579	6,220	09/30/04	0.1429		2
3												3
4												4
5								Amortization expense			2,633	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$56,249.00		$ 7,430,079	$ 1,960,292			$ 169,706	9
	B. Non-Facility Related*											
10							Finance charges				3,525	10
11							Offset of interest income				(170)	11
12							Non-allowable finance charges				(3,358)	12
13							Parent company allocation				178	13
14	TOTAL Non-Facility Related						$	$			$ 175	14
15	TOTALS (line 9+line14)						$ 7,430,079	$ 1,960,292			$ 169,881	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mount Vernon Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039826

CONTACT PERSON REGARDING THIS REPORT Allan Herrmann

TELEPHONE (309) 685-0595 FAX #: (309) 685-9596

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.	N/A		$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,500 B. General Construction Type: Exterior brick Frame block Number of Stories one

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	81,300	1994	$ 60,000	1
2					2
3	TOTALS	81,300		$ 60,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1994	1994	$ 1,229,600	$	40	$ 30,740	$ 30,740	$ 299,715	4
5			1998	1998	5,394		40	135	135	877	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements			1995	3,187		15	212	212	1,975	9
10	Architectural services			1996	4,794		15	320	320	2,360	10
11	Architectural services			1997	1,198		15	80	80	590	11
12	Air compressor			1996	1,230		15	82	82	605	12
13	Electrical			1996	1,710		15	114	114	841	13
14	Exit lighting			1997	1,354		15	90	90	664	14
15	Blinds, wallpaper & paint			1997	3,329		15	222	222	1,633	15
16	Waterproof basement			1997	7,822		15	521	521	3,843	16
17	Windows & doors			1997	2,878		15	192	192	1,416	17
18	Plastering			1997	20,386		15	1,359	1,359	10,023	18
19	Flooring			1997	4,544		15	303	303	1,969	19
20	Gutters			1997	8,933		15	596	596	3,874	20
21	Shutters & windows			1997	1,882		15	125	125	813	21
22	Remodeling of facility			1997	4,153		15	277	277	1,800	22
23	Plumbing			1997	15,420		15	1,028	1,028	6,682	23
24	Electrical service			1997	32,765		15	2,184	2,184	14,196	24
25	Paint & wallpaper			1997	8,366		15	558	558	3,627	25
26	Sidewalk			1997	780		15	52	52	338	26
27	Electrical service			1998	1,340		15	89	89	579	27
28	Flooring			1998	27,771		15	1,851	1,851	12,032	28
29	Remodeling of facility			1998	154		15	10	10	65	29
30	Paint & wallpaper			1998	262		15	17	17	111	30
31	Landscaping			1998	7,964		15	531	531	3,451	31
32	Windows			1998	1,599		15	107	107	695	32
33	Air conditioner			1998	578		15	39	39	254	33
34	Landscaping			1999	1,699		15	113	113	622	34
35	Cabinets			1999	1,220		15	81	81	446	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Renovation of nurse station	1999	$ 6,059	$	15	$ 404	$ 404	$ 2,222	37
38	Security System	1999	1,245		15	83	83	457	38
39	Water heater	1999	1,990		15	132	132	594	39
40	Remodel resident rooms	1999	3,343		15	222	222	999	40
41	Remodel resident rooms	1999	3,477		15	232	232	1,044	41
42	Remodel common room	1999	942		15	62	62	279	42
43	Remodel common room	1999	3,212		15	214	214	963	43
44	Trim	1999	671		15	44	44	198	44
45	Door	2000	984		15	66	66	297	45
46	Concrete Floor Pad	2000	1,500		15	100	100	350	46
47	Air Compressor	2001	1,803		15	120	120	420	47
48	Labor for building improvements	2000	13,971		15	931	931	3,724	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,441,509	$		$ 44,638	$ 44,638	$ 387,643	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 234,980	$ 3,925	$ 22,817	$ 18,892	5-10 years	$ 191,529	71
72	Current Year Purchases	5,444	272	272		10 years	272	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 240,424	$ 4,197	$ 23,089	$ 18,892		$ 191,801	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1997 Ford E150***	1997	$ 13,040	$	$	$	3	$ 13,040	76
77	Resident Transportation	1998 Chevy Corsica***	2002	489	163	163		3	407	77
78	Resident Transportation	1997 Ford Taurus***	2002	978	326	326		3	815	78
79	Resident Transportation	1992 Chevy Van***	2002	900	300	300		3	750	79
80	TOTALS			$ 15,407	$ 789	$ 789	$		$ 15,012	80

*** Cost allocated between 3 facilities

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,757,340	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 4,986	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 68,516	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 63,530	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 594,456	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 1,353 Description: Copier $1,245, Cooler Rental $96, Dishwasher $12
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		100		100
9	TOTALS	$	$ 100	$	$ 100
10	SUM OF line 9, col. 1 and 2 (e)	$ 100			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	$	18	$ 1,196	$	18	$ 1,196	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		23	1,513		23	1,513	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	41	$ 2,709	$	41	$ 2,709	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 32,509	$ 32,509	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,614)	113,564	113,564	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,245	19,245	6
7	Other Prepaid Expenses	400	400	7
8	Accounts Receivable (owners or related parties)	464,445	464,445	8
9	Other(specify): Deposit	4,136	4,136	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 634,299	$ 634,299	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost		1,234,994	14
15	Leasehold Improvements, at Historical Cost	6,276	206,515	15
16	Equipment, at Historical Cost	45,001	255,831	16
17	Accumulated Depreciation (book methods)	(28,651)	(594,456)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investment in subsidiary	1,500	1,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 24,126	$ 1,164,384	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 658,425	$ 1,798,683	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 180,275	$ 180,275	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,904	51,904	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	721,203	(80,499)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 953,382	$ 151,680	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	6,220	1,960,292	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,220	$ 1,960,292	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 959,602	$ 2,111,972	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (301,177)	$ (313,289)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 658,425	$ 1,798,683	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Mount Vernon Care Center
Provider # 0039826
June 30, 2004

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Line 36 - Other		
Accrued Expense	3,370	3,370
Accrued Rent	694,809	(106,893)
Accrued Participation Fees	8,736	8,736
Accrued Insurance	10,071	10,071
Resident Credit Balances	4,217	4,217
Total	721,203	(80,499)

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 46,583	1
2	Restatements (describe):		2
3	**Prior Period Audit Adjustments**	22,469	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 69,052	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(263,993)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Certain expense allocations**		15
16	Other (describe) **added back in column 7**	(106,236)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (370,229)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (301,177)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,367,792	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,367,792	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	216	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 216	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	500	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,139	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,639	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	167	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 167	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule 19a**	661	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 661	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,372,475	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	366,846	31
32	Health Care	673,653	32
33	General Administration	286,502	33
	B. Capital Expense		
34	Ownership	265,119	34
	C. Ancillary Expense		
35	Special Cost Centers	9,212	35
36	Provider Participation Fee	35,136	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,636,468	40
41	**Income before Income Taxes (line 30 minus line 40)****	(263,993)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (263,993)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. A federal tax return is filed for the combined divisions of Caravilla Residential Centers, Inc.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Mount Vernon Care Center
Provider # 0039826
June 30, 2004 **Schedule 19A**

XVII. Income Statement
Line 28: Other

Description	Amount
Vending Income	633
Miscellaneous Income	28
Total	661

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,773	1,946	$ 41,271	$ 21.21	1
2	Assistant Director of Nursing	693	703	11,254	16.01	2
3	Registered Nurses	1,124	1,178	18,071	15.34	3
4	Licensed Practical Nurses	11,916	12,768	172,148	13.48	4
5	Nurse Aides & Orderlies	35,952	38,518	300,037	7.79	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,766	1,834	14,145	7.71	8
9	Activity Director					9
10	Activity Assistants	2,776	2,916	20,564	7.05	10
11	Social Service Workers	2,302	2,546	21,389	8.40	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,284	12,024	81,134	6.75	15
16	Dishwashers					16
17	Maintenance Workers	1,866	1,885	15,374	8.16	17
18	Housekeepers	7,809	8,327	51,660	6.20	18
19	Laundry	7,025	7,445	45,543	6.12	19
20	Administrator	1,792	2,008	41,857	20.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,944	2,096	20,298	9.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	662	758	5,438	7.17	31
32	Other Health Ca see Sch. 20A	1,475	1,569	21,702	13.83	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	92,159	98,521	$ 881,885 *	$ 8.95	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	101	$ 4,661	L1, C3	35
36	Medical Director	monthly	6,100	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	monthly	547	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	12	96	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	545	L11, C3	44
45	Social Service Consultant	10	545	L12, C3	45
46	Other(specify) Office Consultant	monthly	327	L21, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	133	$ 12,820		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	20	$ 812	L10, C3	50
51	Licensed Practical Nurses	108	3,374	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	128	$ 4,186		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Mount Vernon Care Center
Provider # 0039826
June 30, 2004

Schedule 20A

XVIII. A. Staffing and Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Salaries	Average Hourly Wage
Care Plan Coordinator	1,181	1,251	19,396	15.50
Ancillary Clerk	294	318	2,306	7.26
Total	1,475	1,569	21,702	13.83

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carrell Breeze	Administrator	0%	$ 41,857
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 41,857

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. -	$
Administrative Service Fees	99,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 99,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 870
Campbell, Black, Cranine, Hedin		
Ballard & McDonald	Legal	362
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,232

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,180
Unemployment Compensation Insurance	12,239
FICA Taxes	65,908
Employee Health Insurance	17,393
Employee Meals	12,666
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	2,896
TOTAL (agree to Schedule V, line 22, col.8)	$ 156,282

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	885
Health Care Worker Background Check	
(Indicate # of checks performed 105)	735
IHCA Dues	3,168
Miscellaneous Fees and Licenses	349
Expense Allocation	6
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,343

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	680
Seminar Expense	544
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,224

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Care Center
Provider #: 0039826
07/01/03 to 06/30/04

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)			1,232
Allocated from Caravilla Residential Centers, Inc.:			
	Altschuler, Melvoin & Glasser LLP	Accounting	12,461
	American Express Tax & Business Services	Accounting	272
Less: Nonallowable collection fees			
	Cambell, Black, Carnine, Hedin, Ballard & McDonald		(362)
Total (agree to Schedule V, line 19, column 8)			13,603

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4								N/A					
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/03 Ending: 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $3,168**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,373** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **35,136**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,666** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **44%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin and Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	81,134	7,377	4,661	93,172	0	93,172	0	93,172
2. Food Purchase	0	78,319	0	78,319	0	78,319	-12,666	65,653
3. Housekeeping	51,660	8,826	0	60,486	0	60,486	0	60,486
4. Laundry	45,543	9,570	0	55,113	0	55,113	0	55,113
5. Heat and Other Utilities	0	0	37,830	37,830	0	37,830	0	37,830
6. Maintenance	15,374	0	26,552	41,926	0	41,926	0	41,926
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	193,711	104,092	69,043	366,846	0	366,846	-12,666	354,180
9. Medical Director	0	0	6,100	6,100	0	6,100	0	6,100
10. Nursing & Medical Records	584,066	28,248	4,733	617,047	0	617,047	0	617,047
10a. Therapy	0	0	2,805	2,805	0	2,805	0	2,805
11. Activities	20,564	3,376	1,208	25,148	0	25,148	0	25,148
12. Social Services	21,389	7	545	21,941	0	21,941	0	21,941
13. Nurse Aide Training	0	0	100	100	0	100	0	100
14. Program Transportation	0	0	512	512	0	512	0	512
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	626,019	31,631	16,003	673,653	0	673,653	0	673,653
17. Administrative	41,857	0	99,000	140,857	0	140,857	0	140,857
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	1,232	1,232	0	1,232	12,371	13,603
20. Fees, Subscriptions & Promotion	0	0	5,226	5,226	0	5,226	117	5,343
21. Clerical & General Office	20,298	4,728	15,107	40,133	0	40,133	2,100	42,233
22. Employee Benefits & Payroll	0	0	96,909	96,909	0	96,909	59,373	156,282
23. Inservice Training & Education	0	0	384	384	0	384	0	384
24. Travel and Seminar	0	0	1,107	1,107	0	1,107	117	1,224
25. Other Admin. Staff Trans	0	0	653	653	0	653	0	653
26. Insurance-Prop.Liab.Malpractice	0	0	1	1	0	1	42,732	42,733
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	62,155	4,728	219,619	286,502	0	286,502	116,810	403,312
29. Total General Administrative	881,885	140,451	304,665	1,327,001	0	1,327,001	104,144	1,431,145
30. Depreciation	0	0	5,404	5,404	0	5,404	63,112	68,516
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	1,817	1,817	0	1,817	168,064	169,881
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	256,545	256,545	0	256,545	-256,545	0
35. Rent - Equipment & Vehicles	0	0	1,353	1,353	0	1,353	0	1,353
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	265,119	265,119	0	265,119	-25,369	239,750
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	35,136	35,136	0	35,136	0	35,136
43. Other (specify):*	0	0	9,212	9,212	0	9,212	-9,212	0
44. Total Special Cost Ce	0	0	44,348	44,348	0	44,348	-9,212	35,136
45. Grand Total	881,885	140,451	614,132	1,636,468	0	1,636,468	69,563	1,706,031

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	32,509	32,509
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	113,564	113,564
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	19,245	19,245
7. Other Prepaid Expenses	400	400
8. Accounts Receivable-Owner/Related Party	464,445	464,445
9. Other (specify):	4,136	4,136
10. Total current assets	634,299	634,299
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	60,000
14. Buildings, at Historical Cost	0	1,234,994
15. Leasehold Improvements, Historical Cost	6,276	206,515
16. Equipment, at Historical Cost	45,001	255,831
17. Accumulated Depreciation (book methods)	-28,651	-594,456
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	1,500	1,500
24. Total Long-Term Assets	24,126	1,164,384
25. Total Assets	658,425	1,798,683
CURRENT LIABILITIES		
26. Accounts Payable	180,275	180,275
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	51,904	51,904
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	721,203	-80,499
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	953,382	151,680
LONG TERM LIABILITES		
39.Long-Term Notes Payable	6,220	1,960,292
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	6,220	1,960,292
46.Total Liabilities	959,602	2,111,972
47.Total Equity	-301,177	-313,289
48.Total Liabilities and Equity	658,425	1,798,683

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,367,792
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	1,367,792
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	216
7. Oxygen	0
Subtotal - Anciliary Revenue	216
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	500
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	3,139
22. Laundry	0
Subtotal - Other Operating Revenue	3,639
24. Contributions	0
25. Interest and Other Investments Income	167
Subtotal - Non-Operating Revenue	167
27. Other Revenue (specify):	0
28. Other Revenue (specify):	661
Subtotal - Other Revenue	661
30. Total Revenue	1,372,475
31. General Services	366,846
32. Health Care	673,653
33. General Administration	286,502
34. Ownership	265,119
35. Special Cost Centers	9,212
35. Provider Participation Fee	35,136
37. Other	0
40. Total Expenses	1,636,468
41. Income Before Income Taxes	-263,993
42. Income Taxes	0
43. Net Income or Loss for the Year	-263,993

Page